

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004972	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2012
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State hospital complaint.</p> <p>Complaint Number IN00108025 Substantiated; no deficiencies cited.</p> <p>Survey Dates: 10-2-2012 and 10-3-2012</p> <p>Facility Number: 004972</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Franciscan St. Francis Health-Indianapolis was found to be in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cloughlin 11/20/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

5X2X11

If continuation sheet 1 of 1